Transitioning to Value Based Oncology: Strategies to Survive and Thrive

GOING HOSPITAL BASED: GETTING THE DEAL DONE – TRANSACTIONAL ISSUES

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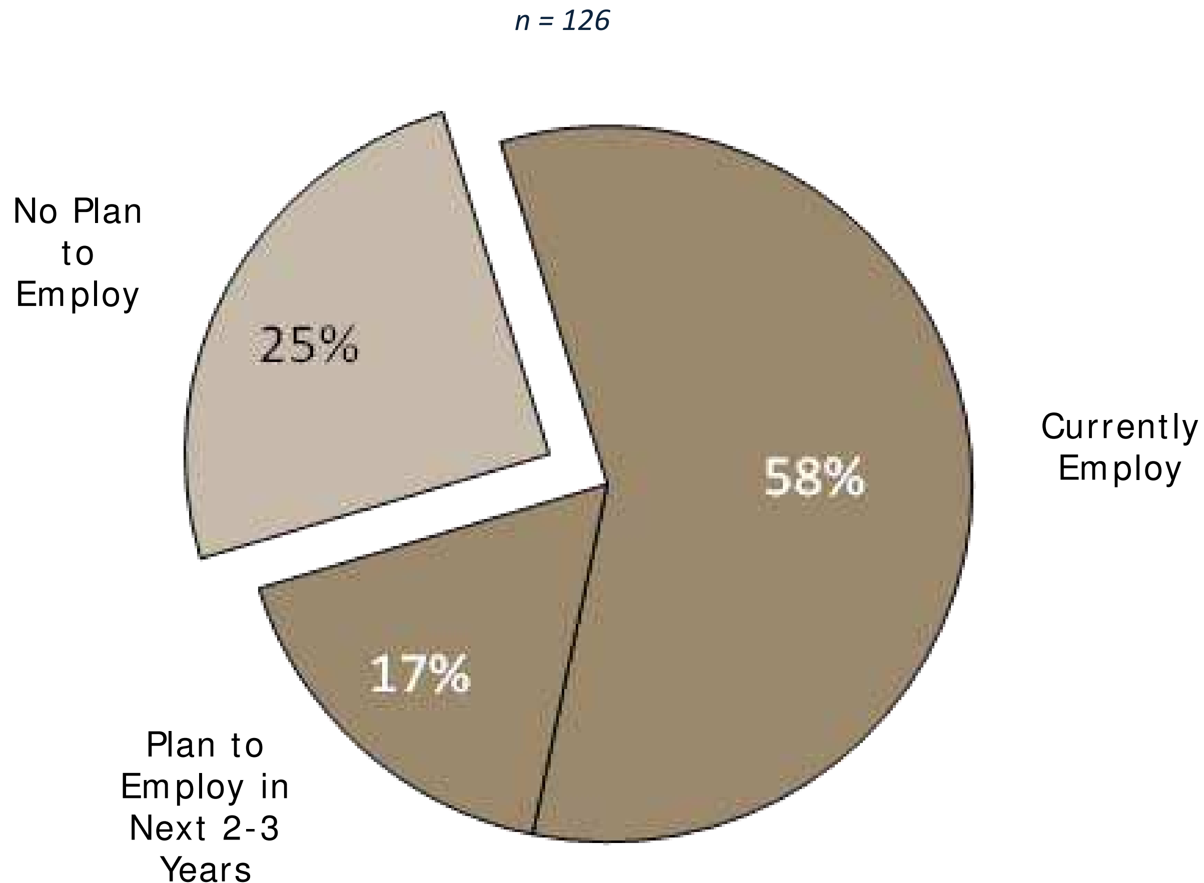
Trends in Hospital-Physician Collaboration

- Employment
- Practice acquisitions and charitable contributions
- Community oncologists moving on-campus or into hospital-affiliated groups
- Integration and alignment for quality and efficiency improvement and for multi-disciplinary care
- Legal developments narrow somewhat options for collaboration

Hospital Employment of Oncologists



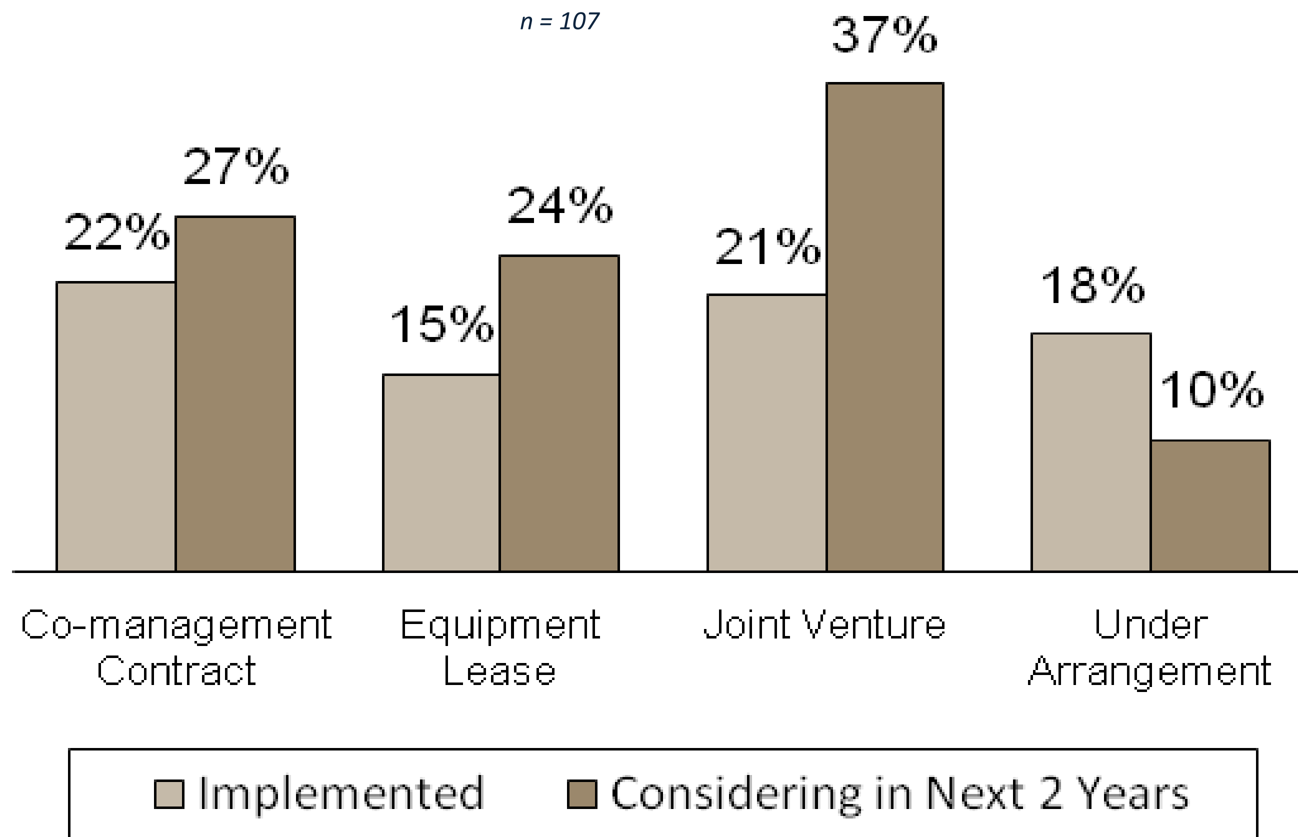
Source: The Advisory Board Company, 2010 Oncology Roundtable

Physician Employment

- Increase in employment by hospitals
- Shortage of oncologists by 2012
- Change in attitude of younger physicians toward employment
- Financial distress of community medical oncologists
- Integrate, align and control destiny
- Less legal risk
  - Joint pricing without violating antitrust
  - Refer and share ancillaries without violating fraud and abuse laws
  - Hire for competitive purposes

Continued Interest in Collaborative Arrangements

Percentage of Hospitals Having Implemented or Considering Alignment Models[1]



Source: The Advisory Board Company, 2010 Oncology Roundtable

Professional Services Agreements

PSAs: Introduction

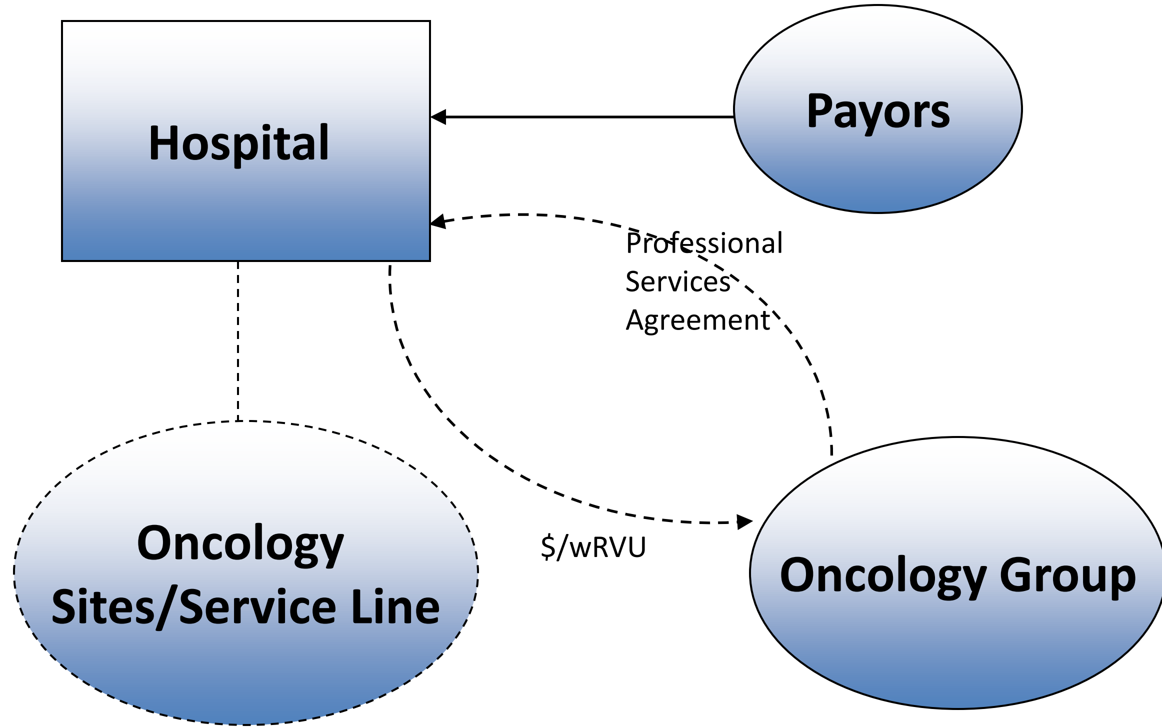
- **Professional Services Agreements**
  - Powerful tool
    - To staff existing Hospital cancer center or develop new hospital facility
    - To convert existing group sites to Hospital-licensed facilities paid at hospital outpatient payment rates
    - Integrate and align Hospital and Group to improve quality, efficiency and operations of Hospital's oncology service line

PSAs: Introduction (cont.)

- Potential economic win-win
- Group paid fair market value compensation on an aggregate fixed fee or wRVU basis
  - Eliminates risk of reimbursement reductions and collection risk (free care/bad debt)
  - Other: purchase of equipment, management services, employee lease?
- Hospital establishes new satellite sites or facility and new book of oncology business
  - Good contribution margin due to combination of hospital rates and physician office cost structure
  - Potential 340B pricing opportunity
- Potential economic losers
  - Payors—higher rates for “same” services
  - Higher patient co-pays

Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing



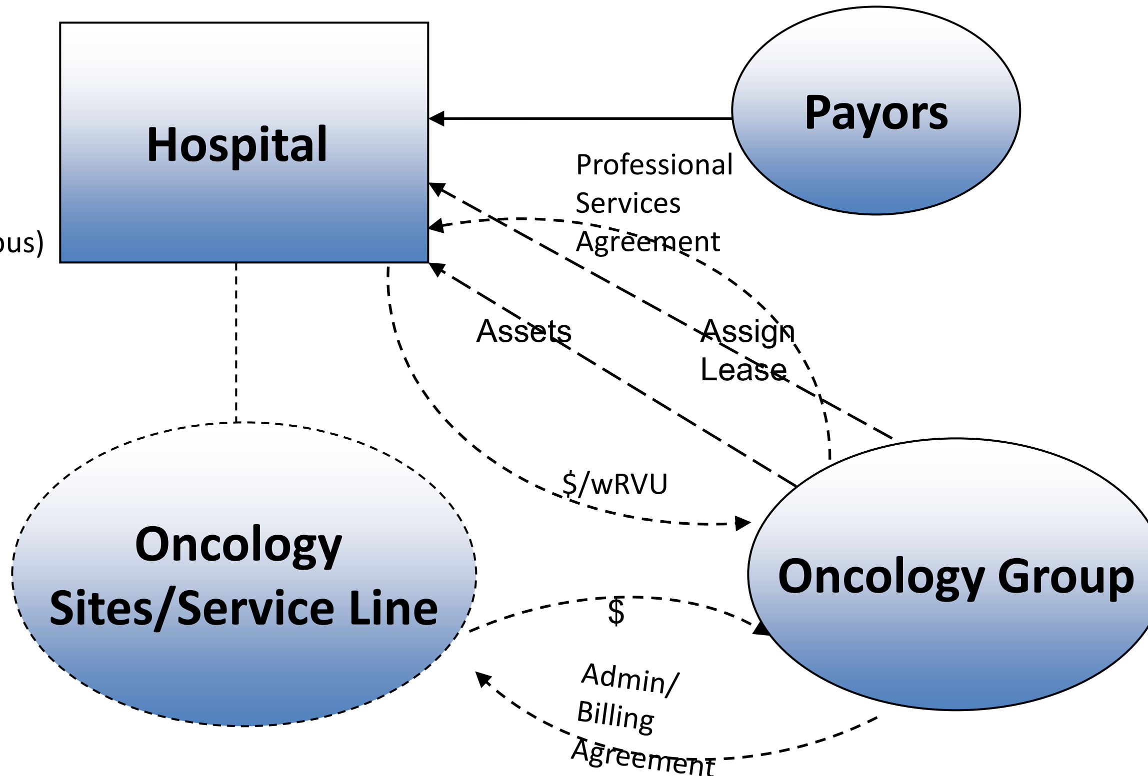
Group provides:
- Physician/NP/PA staffing

PSA Transaction

- Avoid U/A transaction—Group cannot "perform the service"
  - Hospital could take assignment of Group leases from landlords
  - Hospital could purchase Group's FFE and inventory at fair market value
  - Hospital would need to employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules)
- Group can provide all other staff
  - Physicians/NPs/PAs
  - Non-clinical staff at all sites
  - Nurses and techs at on-campus sites

Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing
- Space/equipment
- Nurses/techs (off-campus)



Group provides:
- Physicians/NPs/PAs
- Non-clinical staff
- Nurses/techs (on-campus)
- Administrative services?

Notes:
- PSA on fair market wRVU basis
- Asset/inventory purchase at FMV
- Employee lease /management agreement on a FMV (i) fixed fee, (ii) cost plus, or (iii) percentage of collections or NOI with a FMV floor and cap
- Billing services at fair market percentage of collections or fixed fee per claim?

Principal PSA Legal Issues

- **Provider Based Status Regulations**
  - Within 35 miles of main Hospital campuses
  - Hospital license requirements/Physical space standards
  - CON issues
  - Clinically, financially and administratively integrated
  - Hospital reporting lines
  - Hospital must directly employ mid-levels/techs at off-campus sites (other than NPs/PAs)
  - Oncology group can lease non-clinical staff and NPs/PAs to Hospital
  - No off-campus joint venture with oncology group

Principal PSA Legal Issues

- **340B Drug Pricing**
  - Discount from average manufacturer price generally based on manufacturer's best price
  - Applies only to outpatient drugs
  - Available to DSH hospitals, free-standing cancer hospitals, children's hospitals, CAHs, RRCs, sole community hospitals, FQHCs, and certain special federal grantee programs
  - 8% DSH for RRCs and SCHs; 11.75% for others
  - No applicable to for-profits
  - Must be within 35 miles of main hospital/meet provider-based status standards
  - Effective after first cost report filed with CMS and enrollment (quarterly) with HRSA/OPA—up to 16 months process
  - Supply and extend by contract to retail pharmacies for hospital patients

Principal PSA Legal Issues

- **Stark Law**
  - Under arrangements prohibition: cannot have investment interest in entity (including own medical group) that "performs" the DHS service
  - "Stand in the shoes"
  - Personal services, fair market value or indirect comp exception: fair market value requirement/independent appraisal advisable

Principal PSA Legal Issues

- **Anti-Kickback Statute**
  - Approximate personal services and management contracts and/or space or equipment rental safe harbor
    - Fair market value/independent appraisal strongly advised
  - Some irreducible AKS risk: aggregate compensation not set in advance if wRVU based

Principal PSA Legal Issues

- **Tax Exemption Considerations**
  - No inurement/private benefit
  - No excess benefit transaction
  - Rebuttable presumption of reasonable compensation process
  - Rev. Proc. 97-13 and private use of bond financed space or equipment/duration limitations
    (3 years/2 year out)

Principal PSA Legal Issues

- Can hospital purchase practice or service line(s) as on-going business in connection with PSA?
- Valuation challenges—commercially reasonable, FMV, and can't vary with anticipated referrals
  - Inherent AKS tension between on-going business value and anticipated referrals from selling physicians
  - Tension between Stark law and sale of ancillaries
  - Trade-off of compensation/price?
  - Value on a "re-start" basis?
  - Carve-out governmental business (but, some state all-payor statutes)?
  - No earn-out if sellers in position to refer
- Tax structuring to maximize net payment

Other Key PSA Issues

- Payor pushback
- Role in governance of service line
- wRVU valuation issues
  - Relation to existing physician compensation/ margins on drugs, imaging, labs, etc.
  - Benefits/other continuing expenses
  - New physicians/NPs/PAs
  - Anti-dilution protection
  - Harmonizing with alternative payment arrangements
- No overlap of duties/double payment

Other Key PSA Issues

- USP 797 standards/State pharmacy issues
- Staffing Issues
  - Split staff (off-campus) and salary/benefit differentials
  - Union issues
- Unwind rights
  - Asset repurchase
  - Lease assignment/real estate repurchase
  - Solicitation of employees
  - Data/records access/transfer
  - Systems issues
  - Non-compete exception

Hybrid PSA/Service Line Co-Management Arrangements

What is a Service Line Co-Management Arrangement?

- Independent contract relationship
- Focused on a Hospital's oncology service line
  - Scope?
- To engage physicians as a business and clinical partner in managing, overseeing and improving service line quality and efficiency

Service Line Co-Management Direct Contract Model

Designees

Payors

Hospital

Operating Committee

Designees

Onc Service Line

$

Co-Management Agreement

Oncology Group I

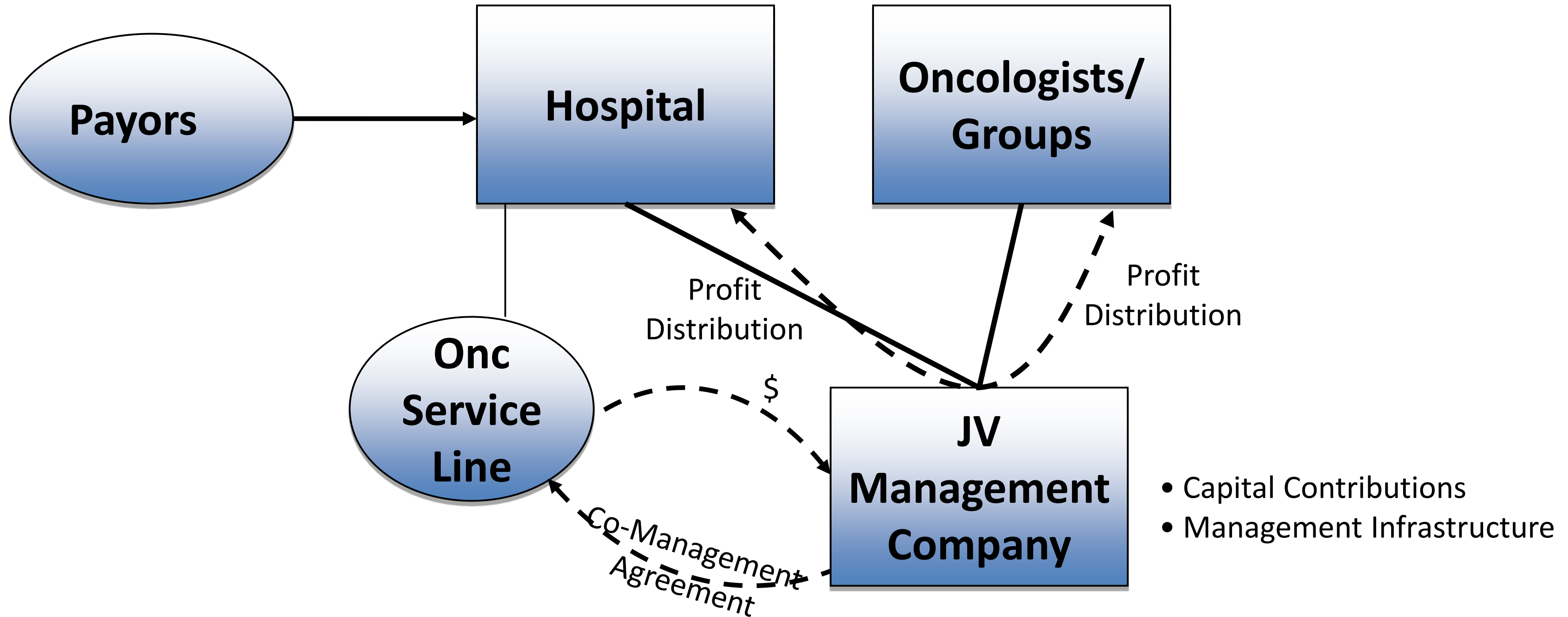
Oncology Group II

Other Group(s)

Hospital-licensed services

- Two, or multi-party contract
- Specifically enumerated services
- Allocates effort and reward between groups

Service Line Co-Management Joint Venture Model



Service Line Co-Management Arrangements

- **Typically two levels of payment to physician managers:**
  - **Base fee** – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - **Bonus fee** – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Aggregate payment generally approximates 2-4% of service line revenues expressed as fixed FMV fee; independent appraisal advisable.

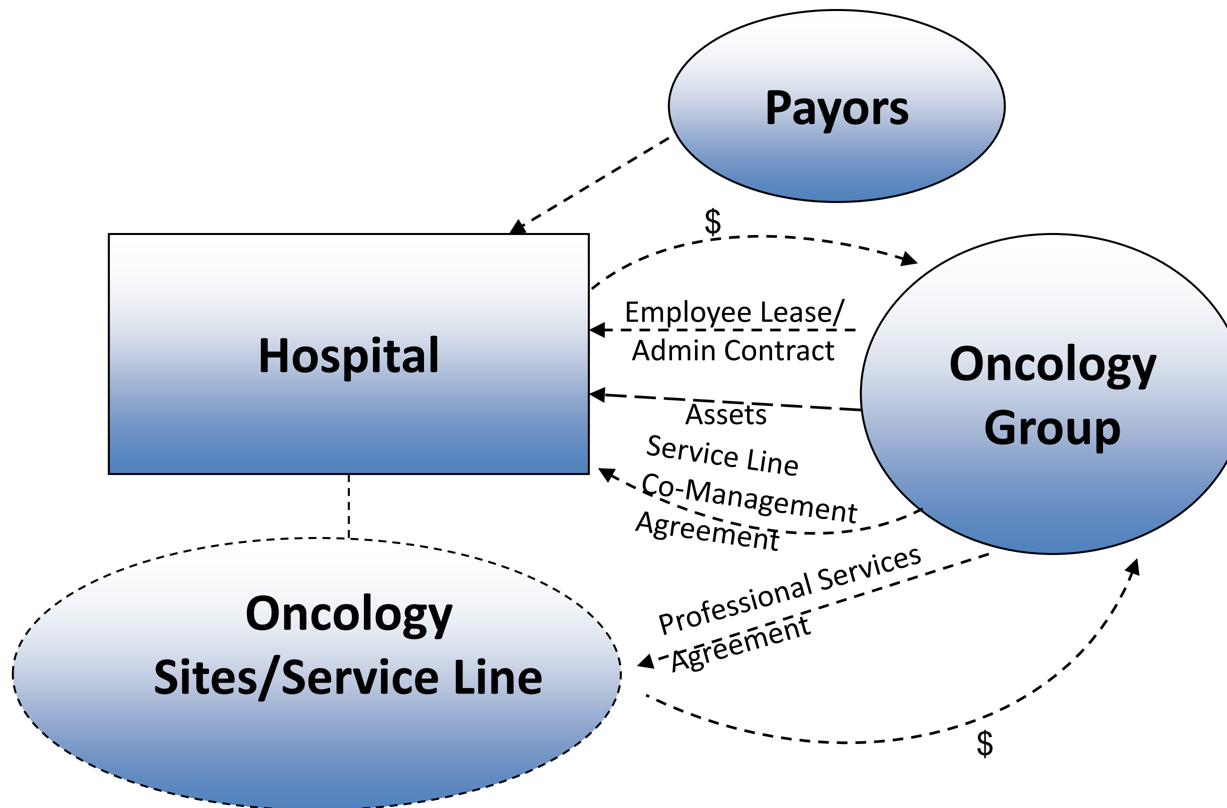
Sample Medical Oncology Performance Standards

- Comply with NCCN/QOPI guidelines
- Increase in patient satisfaction
- Increase in staff satisfaction
- Decrease in infusion site infections
- Substitution of lower cost drugs/items for drugs/items of equivalent efficacy and quality
- Increase in patient accruals for hospital clinical trials

Sample Medical Oncology Performance Standards

- Increase in percentage of patients with written treatment plans at start of infusion
- Increase in percentage of written treatment plans with indication of:
  - Staging
  - Intention of therapy
  - Approved treatment regimen for tumor site/staging
- Increase in percentage of written treatment summaries at completion of course of treatment

PSA with Service Line Co-Management Agreement



Notes:
- Same as PSA arrangement, plus
- Service Line Co-Management Agreement
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Asset/inventory purchase
  - Employee Lease/Administrative Contract – Fixed fee, cost plus or percent of collections with FMV floor and cap
  - Co-management base component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard

Regulatory Considerations

- There are legal constraints on Service Line Co-Management Agreements (*i.e.*, Stark, CMP, and AKS):
  - No stinting
  - No steering
  - No cherry-picking
  - No gaming
  - No payment for changes in volume/referrals
  - No payment for quicker-sicker discharge
  - No reward for changes in payor mix, case mix
  - Must be FMV; independent appraisal required

Key Service Line Co-Management Issues

- Additional work for already busy physicians
- Scope of service line under management
  - Service line co-management services
  - No overlap with, *e.g.*, PSA, employee lease, Medical Director agreement or other agreements
- Performance standards and targets
  - Validation
  - Achievability
  - Reset

Key Service Line Co-Management Issues

- Operating Committee composition and authority
- Term/durability
  - Rev. Proc. 97-13 (5/3 years if 50%+ fixed)
- Dilutive effect of adding physicians due to fixed FMV fee for services rendered
- Cost of independent monitor, valuation, security offering (for JV)
- Some irreducible legal risk

Key Deal Maker/Breaker Issues

- Governance
- Financial Terms
- Term/Duration
- Termination
- Restrictive Covenants
- Unwind Rights
- Addition of New Physicians
- Buy-In/Buy-Out Rights (if applicable)
- Break-Up Fees?
- Arbitration/Dispute Resolution

Valuation Considerations

Presentation Overview

- Healthcare FMV 101
- Current Healthcare Transaction Trends
- Business Valuation Considerations
- Compensation Valuation Considerations

FMV 101: Healthcare Arrangements & Transactions

- Healthcare regulations stipulate fair market value as the applicable **standard of value**.
- The definition of fair market value (*i.e.*, the concept of a hypothetical willing buyer/willing seller) is sometimes counter-intuitive to the lay person.
- Strategic value (or investment value) is often confused with FMV.

FMV 101: Healthcare Arrangements & Transactions

- Generally, any transaction between potential referral sources must be:
  - Consistent with FMV; and
  - Commercially reasonable.
- A transaction can be “FMV,” but not commercially reasonable, and vice versa.
- Healthcare regulations impose specific guidance that directly impacts FMV analysis:
  - Avoid tainted market values.
  - Avoid improper valuation methodologies.

FMV 101: Healthcare Arrangements & Transactions

- Business Valuation (BV) guidance is well established.
  - Healthcare valuation experts follow extensive body of knowledge and standards.
  - Consideration of healthcare regulatory definition of FMV.
- Compensation Valuation (CV) guidance – no formal guidance or standards
  - Stark allows for "any method that is commercially reasonable."
  - Absence of formal guidance facilitates greater valuator judgment regarding approaches and methodologies considered and applied (and related outcomes).
  - FMV outcomes must be defensible.

Current Healthcare Transaction Trends

- Physician Practice Acquisitions
- Physician Employment
- PSAs/Quasi-Employment Agreements
- Co-Management/Pay-for-Performance Arrangements
- On-Call Arrangements
- Medical Directorships

Physician Practices Acquisitions: Overview

- To establish FMV, you must understand and incorporate the proposed terms of the deal.
- Appraisers are polarized with respect to the appropriateness of certain valuation approaches.
- Relationship between purchase price and post-acquisition compensation
- Some transaction consultants can establish unreasonable expectations.

Physician Practices Acquisitions: Valuation Approaches (BV)

- Approaches to valuing physician practices (or any business entity) include Market, Cost and Income.
- A **Market** Approach is generally of little value due to lack of comparability and reliable data.
- A **Cost** Approach restates the entity's balance sheet, including specifically identified intangible assets (*e.g.*, workforce in place, trade name, etc.).
- An **Income** Approach discounts (or capitalizes) expected future cash flows to the buyer.

Physician Practice Acquisitions: Divergent Valuator Opinions

- Certain respected appraisers espouse "Cash is king… A DCF is the sole determinate of physician practice value."
- Other appraisers identify and value specific intangible assets (*e.g.*, workforce in place), and such approach generally results in a higher value than a DCF analysis.
- Relative pros and cons of this difference in opinions?
  - "DCF only" is safer, more conservative?
  - "DCF only" may not foster many (or any?) transactions.

Physician Practice Acquisitions: Post-Acquisition Compensation

- If physician compensation is subject to an increase upon acquisition, the increased compensation is generally treated as an offset to any intangible value.
- The valuation community is largely, but not entirely, in agreement in this regard.

Physician Practice Acquisitions: Pre-Planning the Valuation Focus

- If a practice acquisition consists only of tangible assets, most valuators tend to agree that post-acquisition compensation is unencumbered by the purchase transaction.
- If the goal is to maximize future compensation, there may be no benefit in conducting a business valuation (*i.e.*, a DCF or valuation of specific intangibles).
- A "tangible asset acquisition" coupled with FMV future compensation seems to be a readily defensible approach.

Physician Practice Acquisitions: Other Issues (Medical Oncology)

- Can a physician ancillary service (*e.g.*, chemo infusion) be carved out and sold?
  - Healthcare regulations may prohibit valuing in-office ancillaries based upon future cash flows if such cash flows are dependent upon future referrals of the selling physician(s).
  - An infusion business is not capital intensive, and there are minimal barriers to entry. Therefore, is there any value in an infusion business apart from the expected future referrals?
- 340B Drug Savings/Higher Provider-based Reimbursement Rates
  - Hospitals can't pay for values they create.

Valuation Alternatives

- Potential increase to physician compensation either through PSA or employment with Hospital (subject to FMV constraints)
- Hospital Oncology Service Line Co-Management Arrangements
- Medical Directorships
- Other Administrative Services

Employment Agreements: Overview

- Physician employment is still very active.
- Productivity-based models are in vogue; median compensation per wRVU is a widely viewed metric.
- Employment agreements have many moving parts… the "terms and features" are critically important and typically unique.
- Benefit plans are becoming more robust.

Employment Agreements: “Stacking”

If you label compensation layers by different names, you can stack them higher and higher!

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits

Employment Agreements: Perils of wRVU Models

Hospitals implementing wRVU models have been observed to make errors related to:

- "Total" vs. "work" RVUs
- Failure to consider CPT modifiers and impact on wRVUs
  - Assistant at surgery
  - Multiple procedures
  - Bilateral procedures
  - Reduced procedure
- Physician vs. Mid-level providers
- CMS changes in wRVUs
- New or discontinued CPT codes

Employment Agreements: Other Considerations

- **Personally Performed Services** vs. **Incident-To Services** vs. **Direct Services** rendered by a physician or midlevel provider
- Understand "Normalized" compensation levels by provider as compared to "Reported" compensation (Form W-2, Schedule K-1, Schedule C, 1099, etc)
- Accurate wRVU production levels by physician

Employment Agreements: Other Considerations

- Impact of transaction structure on prospective wRVUs.
  - Considerations for "lost" infusion wRVUs when infusion center becomes hospital-based post-affiliation
- The prospective physician compensation model structure must preserve FMV throughout the full range of likely production outcomes.
- Structure physician compensation model to mitigate unintended consequences.
  - Tiered comp per wRVU model required?
  - Excess compensation tests?

Employment Agreements: Other Considerations

Common physician compensation normalization adjustments:

- Non-clinical compensation
  - External administrative contracts
  - Atypical ancillaries running through practice
- FMV rent; practice owned office/building
- FMV staff benefits
- FMV physician benefits

Employment Agreements: Other Considerations

Common physician compensation normalization adjustments (cont.):

- Non-recurring income and expenses
- Non-operating income and expenses
- Depreciation and inactive asset considerations
- Excess/deficient support staffing levels
- FMV staff compensation considerations

Employment Agreements: Other Considerations

- Can physicians be "made whole" for ancillary profits?
- Defining "normal" ancillaries
  - Oncology – chemotherapy infusion
- Perils of overly complicated compensation structures
- Valuing clinical vs. administrative duties

Quasi-Employment Agreements

- Gaining in prevalence
- Entails a PSA, with the physicians compensated as independent contractors on a wRVU basis; additional payments are made for taxes/benefits and retained practice expenses
- Payment may also be made for “leasing” of non-clinical employees and fixed assets
- FMV considerations – generally the same as employment arrangements
- Should certain payments be pass-through or fixed rather than as a component of a wRVU rate?

Co-Management Agreements: Overview

- **Purpose:** Recognize and appropriately reward participants for developing, managing and improving the quality and efficiency of a particular hospital service line.
- **Scope:** May cover inpatient, outpatient, ancillary and/or multi-site services.
- **Participants:** May include one or more physicians, medical groups or faculty practice plans, or a joint-venture entity owned in part or entirely by participating physicians or medical groups.

Co-Management Agreements: Overview

- Typically two levels of payment under the Co-Management Arrangement:
- **Base Fee:** A fixed annual base fee that is consistent with the FMV of the time and efforts of the participating physicians
  - Includes compensation for service line development, management and oversight
- **Bonus Fee:** A series of predetermined payments that are contingent on the achievement of specified, mutually agreed upon targets
  - Targets must be objectively measurable and based on program development, quality improvement and efficiency.
- Fees must be fixed and commensurate with FMV.

Co-Management Agreements: Overview

Examples of Co-Management Services:

- Clinical improvements
- Work flow process improvement
- Physician and patient scheduling
- Nurse and non-physician clinician oversight
- Patient case management activities
- Credentialing activities
- Materials management
- Medical staff committee service and leadership

Co-Management Agreements: What Drives Value?

- The total fee payable under a co-management arrangement typically ranges from 2% to 4.5% (on a calculated basis) as % of service line net revenue
- The fee is fixed as a flat dollar amount, including both base and incentive components, for a period of at least one year.
- Commonly, the base fee equals 50-70% of the total fee.
- The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management.

Co-Management Agreements: What Drives Value?

Determinants of value include:

- What is the scope of the hospital service line being managed?
- How complex is the service line?
- How extensive are the duties being provided under the co-management arrangement?
- How many physical locations are being managed?

Co-Management Agreements: What Drives Value?

- Size adjustments based on service line revenue:
  - Large programs may be subject to an "economies of scale" discount.
  - Small programs may be subject to a "minimum fee" premium.
- Consider the appropriateness of the selected incentive metrics:
  - Is the establishment of the incentive compensation reasonably objective?
  - What is the "delta" between projected performance and incentive thresholds?

Co-Management Agreements: What Drives Value?

- Consider the appropriateness of the selected incentive metrics (cont.):
  - Are there a sufficient number of metrics given the size of the program?
  - Consider the split of base compensation and incentive compensation.
- Occasionally, certain other services (*e.g.*, call coverage) may be included among the co-management duties. (Some hospitals prefer to embed call coverage in the co-management fee to avoid a separate compensation arrangement with the physicians.)

Co-Management Arrangements: Possible Pitfalls

- Overstated service line/revenue stream
- Redundancy of provided management services (third-party manager involved?)
- Care must be taken to ensure that employed physicians who are part of co-management arrangements are not double paid for their time.
  - Employment compensation based solely on wRVUs is self-normalizing.

Co-Management Arrangements: Possible Pitfalls

- Medical director agreements related to the managed service line must be compensated through the base management fee.
- Existing hospital committees need to be accurately accounted for; may require an adjustment to the Market Approach
- There can be no passive participants. Co-management duties are substantial and require significant time and effort of all participants.
- Lack of an effective compliance program that tracks and monitors the performance and achievement of the base management tasks

Medical Director Agreements

- Is the arrangement commercially reasonable? Are the services needed, and to what extent?
- Is "opportunity cost" an appropriate valuation consideration? Do physician compensation rates differ for clinical vs. administrative services?
- Hourly compensation arrangements may be comforting, but there is much opportunity for abuse.

Summary

- Numerous issues and challenges might arise when exploring hospital-physician employment and/or contractual affiliations.
- Various compliant hospital-physician affiliation structures exist, along with related opportunity for BV and/or CV value recognition.
- All such options need to be carefully assessed and scrutinized for both legal and FMV compliance.

Summary

- There is disagreement in the valuation community regarding the appropriateness of certain valuation approaches. Involving multiple valuation firms in different aspects of the same overall transaction can be risky.

- The health care regulatory and compliance environment is dynamic. Continue to monitor your arrangements for ongoing legal and FMV compliance.

Questions?